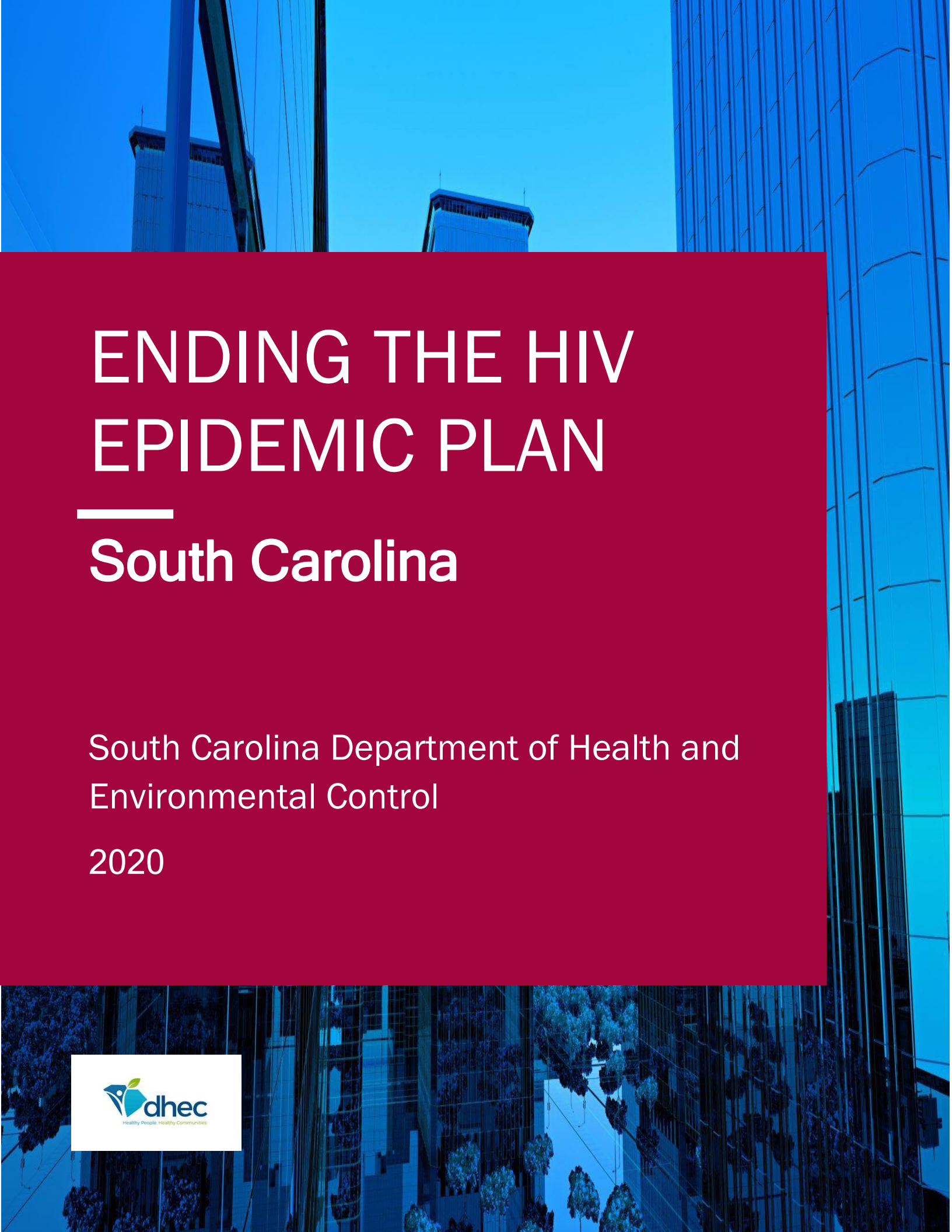

ENDING THE HIV EPIDEMIC PLAN

South Carolina

South Carolina Department of Health and Environmental Control

2020

CONTENTS

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Caresouth-Carolina
Careteam + Family Health & Specialty Care
Challenges Inc.
Charleston Center
Charleston County School District
Charleston Hispanic Association
Circle Park - Chrysalis Center
Circle Park BHS
Citizens Center For Public Life
City of Charleston
Columbia College
Columbia Urban League
Community Advocate
Cooperative Health
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HopeHealth Aiken
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Latino Commission on AIDS
Lexington Sheriff Department
Links, Inc.
Little River Medical Center
Low Country Health Care System
LRADAC
Maud & Company Rehab Service
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Medical University of South Carolina
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Merck
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Midlands Technical College
MUSC OBGYN
Music City PrEP Clinic - Nashville, Tennessee
NAMI Piedmont Tri-County
National Coalition of 100 Black Women, Inc. Columbia (SC) Chapter
New Digital Press DBA En Nuestro Estado
New Horizon Family Health Services
Nuestro Estado
Palmetto AIDS Life Support Services
Harriet Hancock LGBT Center
Palmetto Community Care
PASOs
Pee Dee WIC
PRISMA Health USC Medical Group
Piedmont Care

Positive Coalition Project
Positive Women's Network
Richland School District One
Roper St. Francis Ryan White Wellness Center
Ryan White Wellness Center
Sandhills Medical Foundation
SC AIDS Education and Training Center
SC Appleseed Legal Justice Center
SC Center for Rural and Primary Healthcare
SC Commission for Minority Affairs
SC DHEC
SC DHHS
SC DMH
Wright Wellness Center
SC MOCHA
SC Office of Rural Health
SC Primary Health Care Association
SC Agricultural Worker Health Program
Shalom Recovery Services
Shoreline Behavioral Health Services
South University
Southern AIDS Coalition
Spartanburg Regional Health Services District
St. John Baptist Church
Sumter Behavioral Health Services
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Tandem Health
The Center for ID
The Family Effect
The Phoenix Center
The Wright Wellness Center
Tidelands Community Resources
Trident Technical College
United Way of Greenwood and Abbeville Counties
Unity Empowerment Resource Center
USC
USC School of Information Science
Uplift LGBTQ+ Youth Outreach Center
Upper Midlands Rural Health Network
Upper Savannah Care Services
USC Upstate Collegiate NAACP
ViiV Healthcare
YWCA Upper Lowlands

EXECUTIVE SUMMARY

Purpose:

Ending the HIV Epidemic (EHE): A Plan for America is the U.S. government's aggressive plan to end the HIV epidemic in the United States by 2030. The SC EHE plan aligns with the national plan to achieve and sustain viral suppression and reduce new infections. As with the national plan, South Carolina's goal is to reduce all new HIV infections by 75% during the first five years of the initiative and by 90% in 10 years.

At the heart of the South Carolina EHE plan are four fundamental strategies or pillars:

- DIAGNOSE all individuals with HIV as early as possible after infection;
- TREAT HIV infection rapidly after diagnosis and effectively in all people who have HIV, to help them get and stay virally suppressed;
- PREVENT HIV infections using proven prevention interventions, including PrEP and syringe services programs; and
- RESPOND rapidly to potential HIV outbreaks to get prevention and treatment services to people who need them.

South Carolina Outcome Objectives by Pillar:

DIAGNOSE

By December 31, 2024, at least 90% of South Carolinians living with HIV will be aware of their HIV status.

TREAT

By December 31, 2024:

- More than 90% of newly diagnosed individuals will be linked to care within 14 days of receipt of their HIV test results.
- More than 75% of newly diagnosed individuals will be initiated on antiretroviral therapy within 30 days of receipt of their HIV test results.

PREVENT

By December 31, 2024, there will be a 75% reduction in new HIV cases in South Carolina.

RESPOND

By December 31, 2024, DHEC and community partners will have all systems in place for seamless responses to HIV outbreaks in South Carolina.

The interventions proposed in the South Carolina EHE plan are infused with a commitment to normalizing HIV testing, creating an enabling environment for HIV treatment and care services, and reinforcing that discrimination against persons living with HIV will not be tolerated. Anti-stigma efforts will include supporting an enabling environment for ending HIV criminalization in South Carolina.

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Ending the HIV Epidemic Plan – South Carolina
Website: https://scdhec.gov/infectious-diseases/hiv-std-viral-hepatitis

INTRODUCTION

Ending the HIV Epidemic: A Plan for America (EHE) is the U.S. government's aggressive plan to end the HIV epidemic in the United States by 2030. EHE is the operational plan developed by agencies across the U.S. Department of Health and Human Services (HHS) to pursue that goal. The plan builds on proven successful interventions and leverages critical advances in HIV prevention and care by coordinating the successful programs, resources, and infrastructure of many federal agencies and offices. In its first phase, the initiative is focusing on areas where HIV transmission occurs most frequently - notably seven states in the Southern U.S. including South Carolina.

At the heart of the South Carolina EHE implementation plan are four fundamental strategies or pillars as noted in the national plan:

- **DIAGNOSE** all individuals with HIV as early as possible after infection;
- **TREAT** HIV infection rapidly after diagnosis and effectively in all people who have HIV, to help them get and stay virally suppressed;
- **PREVENT** HIV infections using proven prevention interventions, including PrEP and syringe services programs; and
- **RESPOND** rapidly to potential HIV outbreaks to get prevention and treatment services to people who need them.

Landmark biomedical and scientific research advances have led to the development of many successful HIV treatment regimens, prevention strategies, and improved care for persons living with HIV. Notably:

- Owing to major advances in **antiretroviral therapy**, persons living with HIV (PLWH) who take their medicine as prescribed can be expected to live long, healthy lives and have effectively no risk of sexually transmitting HIV to a partner.
- Building on nearly three decades of biomedical and behavioral science, there are now **models of effective HIV care and prevention** aimed at diagnosing HIV and engaging and retaining PLWH ineffective care.
- **Pre-exposure prophylaxis (PrEP)**, currently a daily regimen of antiretroviral drugs, has proven highly effective in preventing HIV infection for individuals at high risk, reducing the risk of acquiring HIV by up to 97 percent.
- **New laboratory and epidemiological techniques** facilitate a swift response to emerging HIV outbreaks by giving public health leadership tools to pinpoint where HIV infections are spreading most rapidly to stop the further spread of new transmissions.

SOCIAL AND HEALTH INEQUITIES

We cannot end HIV without reducing health disparities and inequities. In South Carolina, the disease burden among African Americans is unacceptable. Challenging social and environmental conditions contribute to persistent and growing HIV-related health disparities - such as higher rates of HIV infection and poorer health-related outcomes - for people of color, most strikingly African Americans. In 2018, there were 715 new HIV infections in South Carolina. Of these, 65% were among African Americans even though

they make up only 26% of the population. While still a relatively small number, the rate of Hispanic/Latino males living with an HIV diagnosis is 2.7 times that of White males.

In South Carolina, these health-related disparities for people of color are influenced by health inequities including inadequate access to care, poverty, homelessness, lack of education, lack of social support networks, lack of services in certain geographic areas, and lack of culturally and linguistically appropriate services. These conditions affect the ability to receive HIV treatment, care, and support.

Finally, unacceptable disparities exist for Men who have Sex with Men (MSM) and homophobia, intolerance, and access to health services all must be addressed moving forward. In 2019 in South Carolina, 77 percent of new HIV cases in 2019 involved men; and 77 percent of new cases involved gay, bisexual, and other men who have sex with men.

STIGMA AND DISCRIMINATION

People living with HIV and those at risk of infection experience additional barriers to testing and treatment when they encounter discrimination and prejudice due to attitudes, beliefs, practices, policies, and services that perpetuate negative social perceptions about HIV. The interventions proposed in the South Carolina EHE Plan are infused with a commitment to normalizing HIV testing, creating an enabling environment for HIV treatment and care services, and reinforcing that discrimination against PLWH will not be tolerated. Anti-stigma efforts will include supporting an enabling environment for ending HIV criminalization in South Carolina.

EHE in South Carolina will maximize the availability of lifesaving, transmission-interrupting treatment for HIV, saving lives, and improving the health of South Carolinians. It will move South Carolina from a history of having an unacceptable disease burden and poor health outcomes to a future where new infections are rare and those living with the disease have normal lifespans with few complications.

HIV/AIDS in SOUTH CAROLINA

In June 1981, the CDC published a report which documented five cases of Pneumocystis carinii pneumonia in otherwise healthy young men in Los Angeles, California; these would be considered the first cases of AIDS identified in the United States. That report would prompt AIDS case reports from other areas of the U.S. such as New York, San Francisco, and in 1982, South Carolina.

Since 1986, more than 31,337 people have been diagnosed with HIV infection (including AIDS) in South Carolina through December 2019. During 1985-1990 an average of 860 cases were diagnosed each year. In the subsequent three years (1991-1993), newly diagnosed HIV/AIDS cases averaged 1,306. The increase during this period was in part due to the artificial rise in AIDS cases as a result of the change in case definition in 1993. For the past five years, the average number of newly diagnosed cases has been about 766 per year. According to the CDC however, many more people are infected but have not been tested.

Some of the changes over time in numbers of new cases are largely the result of reporting patterns or targeted testing initiatives. The initial steep rise in the epidemic reflects the early years when less was known about the transmission of HIV and effective medical treatments did not exist. As a result, infection rates increased, and more HIV-infected individuals went on to develop AIDS. Most experts believe that when more was learned about HIV and the behaviors involved in its spread, effective prevention strategies reduced the overall number of new infections, and medical treatment, for some individuals, postponed the onset of AIDS. In more recent years, however, there is concern nationally that the epidemic may grow, particularly among young men who have sex with men.

Since 1994, new anti-retroviral drugs and strengthened care services have contributed to a decline in overall AIDS deaths. This decline is illustrated by the 121 AIDS related deaths in 2019, a 34 percent decrease from the 229 deaths in 2009. It is important to note that despite the decline in deaths due to AIDS and the apparent stabilization of the number of new HIV/AIDS cases diagnosed annually, the prevalence of HIV infection (the number of people estimated to be living with HIV/AIDS) is continuously increasing. The number of people living with HIV/AIDS (PLWHA) at the end of each year has increased 26 percent from 2009 to 2019. Data presented in this section will show that it is also important to note there are differences among certain populations in the number and rate of new and prevalent infections in SC.

For more details on SC HIV/AIDS surveillance reports please visit SC DHEC website https://scdhec.gov/hiv-aids-std-data-reports

Different groups are impacted differently by HIV/AIDS as seen in this section below.

SEX, RACE/ETHNICITY, AGE, RISK EXPOSURE, AND CONTINUUM OF CARE

Figure 1: S.C. HIV/AIDS Incidence and Prevalence impact by sex

SEX	S.C. Total Population, 2019 est.		Total Estimated Living With HIV/AIDS, 2019		Total HIV/AIDS Diagnosis, 2018-2019	
	No.	%	No.	%	No.	%
Male	2,493,139	48%	14,599	72%	1,241	80%
Female	2,655,575	51%	5,735	28%	315	20%
Total	5,148,714		20,334		1,556	

Sex: Figure 1 shows the impact of HIV on the men and women in South Carolina.

Sex. Men are disproportionately affected by HIV/AIDS. Men make up 48 percent of South Carolina's total population but comprise 72 percent of PLWHA (prevalence). HIV/AIDS diagnosed cases during the two-year period 2018-2019 gives an estimate of more recent infections or potentially emerging populations.

Race/Ethnicity. African Americans are disproportionately impacted by HIV/AIDS in South Carolina. African Americans comprise 27 percent of the state's total population, yet 68 percent of the total people living with HIV are African American. Five percent of total cases are Hispanics, who comprise six percent of the state's population as shown in graph below.

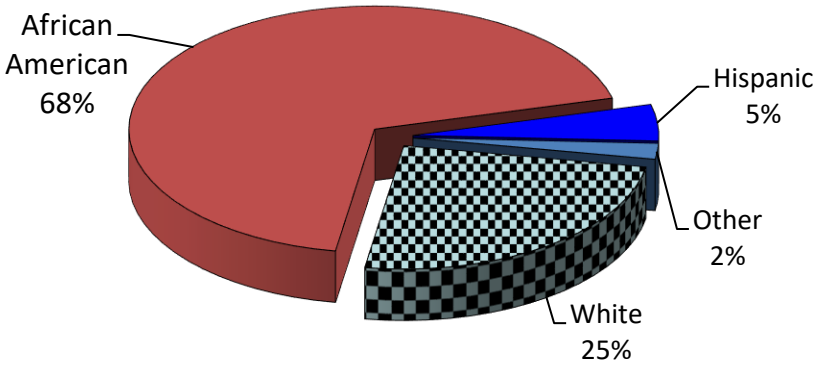


Figure 2: Proportion of persons living with HIV/AIDS by race/ethnicity, 2019

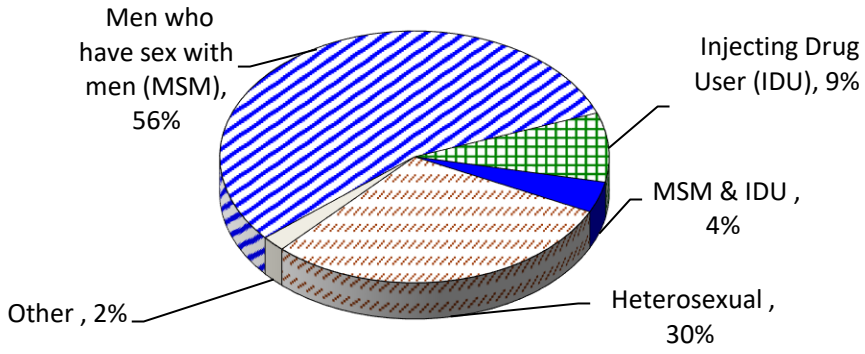
Age. When analyzing HIV/AIDS data by age, the differences between the two measures (incidence and prevalence) become pronounced. With incidence, 69 percent of new cases diagnosed in 2018-2019 are under the age of 40, and with 2019 prevalence, 70 percent are over the age of 40. For incidence, people age 20-29 comprise the largest proportion, 41 percent of newly diagnosed cases (20-24 19 percent and 25-29 22 percent), and people 30-39 comprise 22 percent. People under the age of 20 comprise just six percent of new diagnosis. For prevalence, 20 percent are age 40-49, 30 percent are age 50-59, and 20 percent are age 60+ (Figure 3).

Figure 3: S.C. HIV/AIDS impact by age

Age Range	SC Population		Total Persons Living with HIV/AIDS, 2019		Total HIV/ AIDS Diagnosis, 2018-2019	
	No.	%	No.	%	No.	%
<15 Years	923,180	18%	98	0.50%	<5	0.10%
15-19 Years	324,659	6%	85	0.40%	86	6%
20-24 Years	330,743	6%	570	3%	289	19%
25-29 Years	353,271	7%	1,571	8%	335	22%
30-39 Years	649,573	13%	3,646	18%	350	22%
40-49 Years	618,709	12%	4,116	20%	233	15%
50-59 Years	672,388	13%	6,175	30%	170	11%
60+ Years	1,276,191	25%	4,073	20%	92	6%

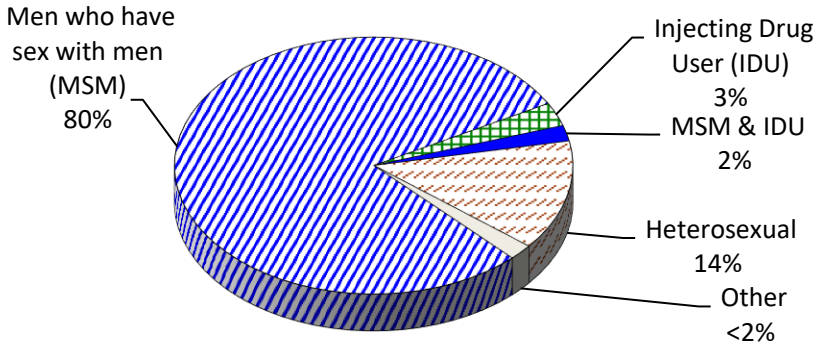
Risk Exposure. Of the cases with an identified risk factor, men who have sex with men was the highest reported risk factor in 2019 for PLWHA (56 percent). Heterosexual contact accounted for 30 percent of reported risk factors. Nine percent reported a risk of injecting drug use (IDU). Four percent reported the combined risks of MSM and IDU (Figure 4).

Figure 4: Proportion of persons living with HIV/AIDS by risk exposure, 2019



Note: Total excludes cases with no risk identified.

Figure 5: Proportion of HIV/AIDS cases diagnosed 2018-2019 by risk exposure

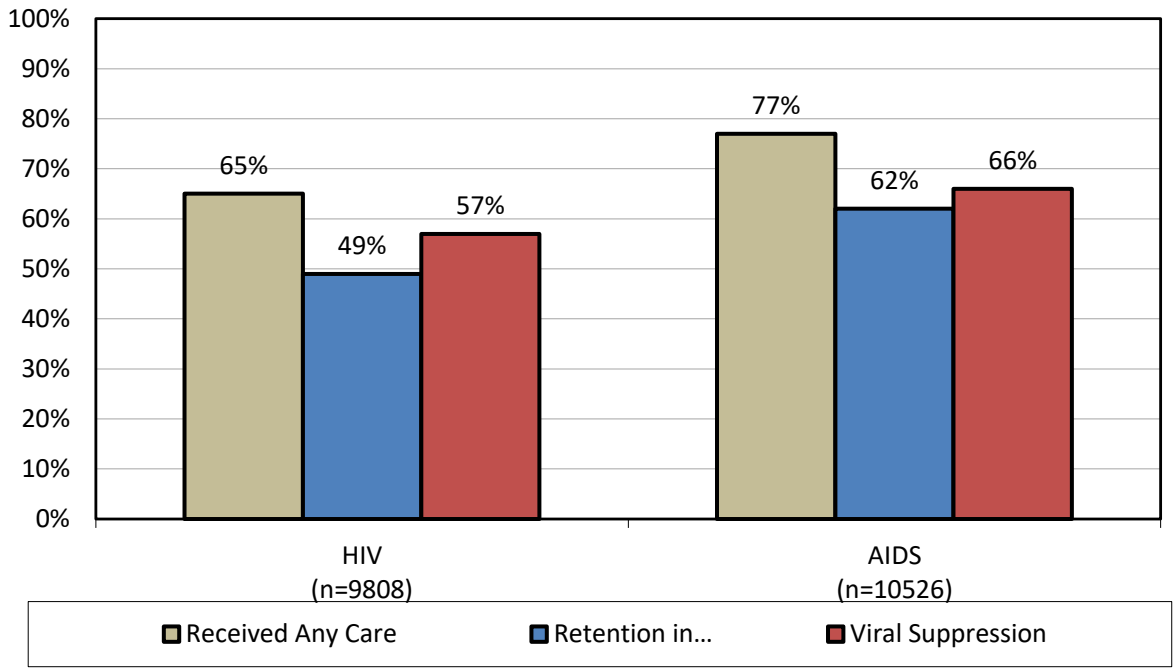


Note: Total excludes cases with no risk identified.

Figure 5 shows reported risk for people newly diagnosed with HIV/AIDS during 2018-2019. The proportion of new cases with a reported risk of MSM was 80 percent and with a reported risk of heterosexual contact was 14 percent; IDUs made up three percent and the combined risk of MSM and IDU two percent. Thirty-three percent of new cases have no risk identified. Over time, the proportion of cases with no risk identified in a given year decreases as risks are determined through follow-up surveillance activities.

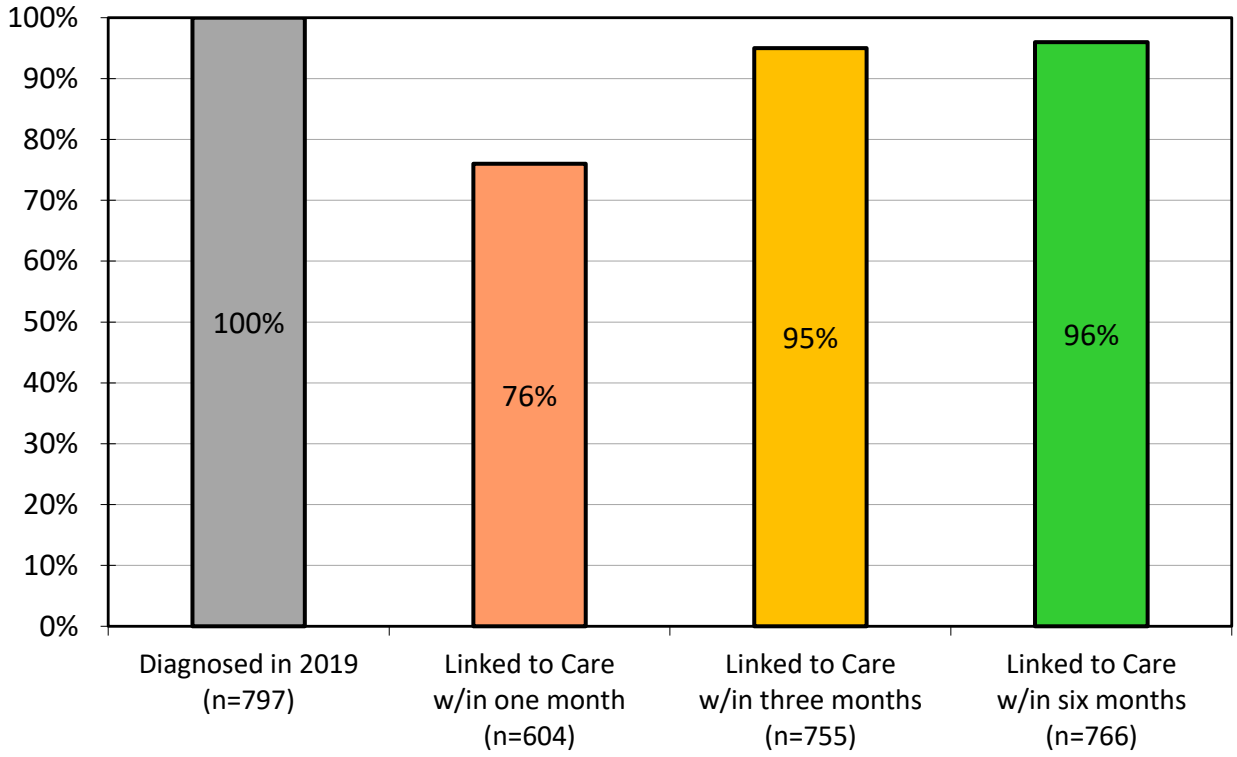
HIV Continuum of care - Prevalence. Figure 6 show the HIV continuum of care, PLWHA received any care, retained in care and viral suppression by stage of diagnosis.

Figure 6: Percentage of PLWHA engaged in each step of the HIV continuum of care, by diagnosis, 2019



HIV Continuum of Care - Linked to Care (New diagnosis). To optimize HIV outcomes, prompt linkage to HIV medical care is necessary, ideally ensuring that persons enter HIV medical care very soon after initial HIV diagnosis. A person is considered linked to HIV medical care if there is at least one CD4 or viral load test result within three months of the initial diagnosis. Figure 7 shows the percentage of people diagnosed in 2019 who were linked to care within 1, 3, and 6, months of diagnosis.

Figure 7: Percentage of persons linked to care within 1, 3 and 6 months after HIV diagnosis among total number of persons diagnosed with HIV infection in 2019.
Note: The national performance standard for linkage to care is within one month of diagnosis.



Data source: HIV/STD Surveillance, Assessment and Evaluation division (11/2020)

HIV Care Continuum Methodology

The HIV Continuum of Care is a metrics developed by the Centers for Disease Control and Prevention (CDC) as a way to monitor and report on the objectives outlined in the National HIV/AIDS Strategy for the United States, specifically: linked to care, received any care, retained in care, and viral suppression.

- All persons with reported diagnoses of HIV infection (regardless of stage of disease) through year-end 2019, who were alive at year-end 2019
- All ages
- Last known state of residence is South Carolina
- CD4 and viral load tests (used as a surrogate for evidence of HIV care)

- ‘Linked to care’ is defined as “persons with a CD4 or viral load test within 3 months after HIV diagnosis, among persons newly diagnosed with HIV infection in 2019”
- ‘Received Any Care’ is defined as “persons with ≥1 CD4 or viral load test result during 2019”
- ‘Retention in Continuous Care’ is defined as “persons who had ≥2 CD4 or viral load test results at least 3 months apart during 2019”
- ‘Viral Suppression’ is defined as “persons who had a Viral Load <=200 copies/mL at most recent test during 2019”

COMMUNITY ENGAGEMENT/ EHE PLANNING PROCESS

The South Carolina EHE process builds on a process that began in 2019 - and continues as an ongoing initiative of the South Carolina Department of Health and Environmental Control (DHEC) under the umbrella of *Ending the Epidemics SC* (EtESC). The EtESC initiative was established in 2017 to impact the synergistic epidemics of HIV, sexually transmitted infections (STIs), viral hepatitis, and substance use disorder (SUD).

The purpose of the EHE engagement process was to assure broad-based community support, particularly to understand the implications for rural areas in the state which bear a disproportionate burden of HIV disease and for whom access to treatment and care presents unique challenges. The overarching goal of the engagement process was to advise DHEC on program enhancements and improved coordination resulting in a shared vision to achieve EHE goals.

The engagement process began with the support of and involvement of the existing HIV Planning Council (HPC). This statewide group is composed of community advocates, PLWH, and service provider partners who are all uniquely qualified to advise on the landscape of HIV prevention and care in the jurisdiction. In order to bring new voices to the conversation, a decision was made to form an Ending the Epidemics statewide work group with both memberships from the HPC and representative stakeholders not currently engaged in HIV planning. Out of this statewide work group, an Ending the Epidemics Steering Committee was formed. This steering committee set and/or created the foundation of the efforts and was composed of a mix of people living with HIV, prevention and care providers, advocates, and representatives from state and local health departments. To foster engagement, DHEC has taken advantage of staff members in key regional roles whose primary purpose has been to deepen community engagement.

As the planning process unfolded, the decision was made to pay particular attention to the input of PLWH. In addition to involvement in the Steering Committee, a decision was reached that several consultations at key points in the needs assessment process should be exclusive to PLWH. This aspect of the planning process was deemed critical for successfully including broad voices of community members affected by or living with HIV. Recognizing that some PLWH were afraid to participate in the EHE planning process, we are making combatting stigma and fear significant parts of our EHE implementation. With the help of the Steering Committee, DHEC was able to engage with partners who provide prevention, care, and other essential services for people with HIV and at high risk for HIV. Local HIV service providers are seen as key partners in understanding gaps and barriers to HIV prevention and care programs. This effort also targeted health and social service providers that engage with the communities we wish to reach (e.g., criminal justice system, youth services, addiction treatment centers, etc.).

In collaboration with the Steering Committee, an extensive series of forums was established to gather a broad perspective on gaps and barriers and to reach communities experiencing health disparities and that have either not had access to prevention and care programs or who have not felt included as part of the intended audience for such programs. In total, some 24 forums were planned at the statewide and regional levels to assure community engagement.

The first series of regional forums focused on the Diagnose/Prevent strategies. An overview of the EHE process was presented and a set of questions posed which invited a discussion of strengths in existing testing and prevention programs in the region as well as gaps and unmet needs. These rich discussions yielded important information which led into the planning process. The Diagnose/Prevent needs assessment forums were repeated in each of the four SC Public Health Regions: Upstate, Midlands, Lowcountry, and Pee Dee.

The second set of forums were regionally based and focused on the Treat strategy with discussion questions centered on successes and unmet needs in HIV treatment and care. These conversations attempted to look at issues of rapid linkage to care, early initiation of ART, clinical services, and rapid reengagement in care when clients fall out of care. As with the previous forums, these were held in all four SC Public Health Regions.

Given the concern about health outcomes for Latinx persons - and the unique challenges faced - a series of three Spanish-language forums for the Latinx Spanish speaking population was held in late September-mid October. Participants for these forums were recruited under the leadership of two SC DHEC staff members (the Hispanic Services Coordinator and the Human Services Coordinator) and the HPC Prevention Chair, all of whom are bilingual. A spreadsheet/database of all agencies in SC serving the population was created and used to share emails, fliers, and other advertisements for the forums as well as follow-up calls. Live interviews and social media were also used to promote and recruit participants for the forums.

In addition to these regional forums, two focused statewide forums were conducted to address unmet prevention needs and to focus attention on the “RESPOND” strategies in the EHE planning guidance. The Prevent forum - co-sponsored by the SC Department of Alcohol and other Drug Abuse Services (DAODAS) - sought to engage a broad range of stakeholders to address the unmet needs of persons who inject drugs (PWID) with a focus on providers of substance use disorder (SUD) and opiate use disorder (OUD) services. South Carolina law currently prohibits the possession or distribution of drug paraphernalia (syringes), but DHEC and DOADAS remain committed to understanding expoloring ways that the HIV prevention needs of PWID can be served in spite of this barrier. The conversation and recommendations focused on all the ways in which legal components of syringe services programs (SSPs) could be moved forward while continuing to provide data for decision-makers regarding potential changes to SC paraphernalia laws.

The second statewide forum brought together a wide range of stakeholders to analyze current strengths and challenges in cluster response, focused on the RESPOND outcome objectives. This forum included DHEC staff, CDC surveillance and program staff, and external stakeholders including clinicians, epidemiologists, and PLWH. This forum produced a series of insights about current challenges to cluster response and articulated a clear set of recommendations for enhancing this process moving forward.

The initial planning process resulted in the recommendation of a follow-up series of forums focused on intervention recommendations. These forums were deliberately designed with fewer participants with specialized expertise to make concrete recommendations. These forums each began with a review of findings from the previous

regional forum and presented the outcome objectives for the particular EHE strategy/strategies that were the focus of the consultation. A series of eight forums were held - two per Public Health Region. The first set solicited intervention suggestions for DIAGNOSE/PREVENT strategies in the EHE framework and generated excellent recommendations for HIV testing and prevention, especially focused on biomedical prevention intervention. The second set of recommendations were captured in a similar forum series; the difference is these were focused on the TREAT strategies. These recommendations focused on overcoming barriers and addressing unmet needs in linkage, retention, and treatment and care using the Treat outcome objectives as the starting point.

In total, some 24 community forums were held across the state over the course of the needs assessment/situational analysis process. These forums engaged nearly 200 South Carolinians from all regions of the state. Participants were male, female, and transgender persons, urban and rural, and ranging in age from early 20s to late 60s. This rich and diverse set of stakeholders included clinicians, prevention workers, advocates, representatives of local health departments, persons living with HIV, individuals providing SUD/OUD services, surveillance staff, and community advocates. This successful process embraced the ideals of community engagement and resulted in excellent guidance for unmet needs and intervention recommendations summarized below.

SITUATIONAL ANALYSIS/ STAKEHOLDER INPUT

The following section summarizes the major themes shared by stakeholders throughout the planning process and forums outlined above. Key themes are categorized into barriers, gaps in services, successes & needs by public health region and special populations.

BARRIERS

***Lack of Transportation*.** The most frequent and often first reported barrier to HIV prevention, testing, and care across all Public Health Regions was lack of transportation. Lack of readily available transportation inhibits or delays access to testing sites, medical appointments, and medication, especially for those who do not take medication deliveries at home for confidentiality reasons. Suggestions made to address this barrier included:

> *Public transportation in rural areas just doesn't exist… and most of South Carolina is rural.*
>
> *-PLWH stakeholder*

- expanding locations of services to include more readily accessible locations such as pharmacies, community events, community centers, and primary care providers
- expanding collaborations among service providers to share transport vehicles, perhaps those used in outreach activities
- expanding outreach services to "meet the client where they are – geographically"
- expanding telehealth combined with home HIV testing, PrEP education, and treatment

Lack of accessibility. In addition to a lack of transportation, stakeholders shared a lack of general accessibility of both prevention and care services due to long distances, too few providers, and a lack of comprehensive services under one roof (i.e., "one-stop shopping" or "bundled services"). Providers and other stakeholders pushed for opt-out, routine rapid HIV testing both in all clinical settings (e.g., ERs, primary care offices, STI settings) and alongside other routine health checks (e.g., blood pressure checks, diabetes testing, cholesterol testing) taking place in the community such as at health fairs. Other suggestions included embedding more Ryan White services in federally qualified health centers and provide more outreach services to "meet the client where they were – literally meeting them in their own safe space."

> *Don't always force us to come [to the agency] for services – a big help would be for the services to come to us.*
>
> *-PLWH stakeholder*

Stakeholders also discussed one of the key barriers to PrEP is a lack of access to providers who are willing to prescribe this medication perhaps because of their own lack of knowledge about PrEP, lack of skills to communicate with their clients about PrEP, or their own biases about "those kind of people" who they deem might benefit from PrEP. Prioritizing partners of PLWH for PrEP access at Ryan White sites and increasing education and training about PrEP among primary providers and their staff were suggested actions to address these barriers.

Further, providers, PLWH, and other stakeholders insisted that the expeditious initiation of ART in people newly diagnosed with HIV remains a high priority and as such, expansion of a rapid ART protocol needs to be shared and engaged statewide to enhance access to rapid ART.

***Lack of education*.** Across all public health regions, stakeholders discussed the need for basic HIV education for the general public. Many reported that the public's general lack of HIV education and awareness contributes to the pervasive stigma that further complicates prevention and care efforts. Stakeholders suggested statewide-level funding to purchase and disseminate anti-stigma messaging throughout the state as well as utilizing stigma reduction resources already available through such entities as CDC. Further, they suggested that this education and messaging should include the following information: what HIV is, how transmission occurs, and how it is treated with reinforcement messages that, "HIV is not a death sentence" and "viral suppression is the goal: undetectable equals untransmittable (U=U)." Additional suggestions to address the lack of education among the public included expanded comprehensive sexuality education in schools and utilizing social media (e.g., Facebook) and apps (e.g., PrEPlocator and hook-up sites such as Grindr and Scruff) to share information and link to people to services.

In addition to the general public, stakeholders discussed the need for education among non-HIV-specific providers such as primary care providers, mental health providers, substance abuse counselors, nurses, social workers, and others who work with high risk populations or PLWH. This education and training would include HIV prevention and care, PrEP, PEP, and linkage to services.

> *We don't see HIV information out there anymore. We see PrEP commercials but they're always about MSM. Other people need to know about PrEP, too.*
>
> *-Stakeholder*

Another education/awareness component discussed at numerous stakeholder forums was the need for a user-friendly directory of available prevention and care services easily accessible by both the public and by providers. Too often, PLWH do not know where (or at which agency) prevention and Ryan White services are available or even if they are available in their area. Unfortunately, many agency staff are also unaware of the services available in their area and therefore these resources go un-identified and un-used by those in need.

Poor customer service. Across all public health regions, PLWH and other stakeholders discussed the barrier of "poor customer service" in prevention and care efforts. Poor customer service included: the use of disrespectful, judgmental and outdated language based on HIV status, race, class, sexual orientation, and gender identity (e.g., "full-blown AIDS," "AIDS patient," "he/she" instead of "they"),extremely long wait times, lack of available appointments, confidentiality breaches, lack of rapport with case managers and other staff, lack of comprehensive services under one roof, lack of bilingual staff, and non-client-centered care. Stakeholders, especially PLWH, strongly suggested that providers and their staff (clinical and non-clinical) receive customer service training that is client-centered and focused on cultural sensitivity. Further, across the state, stakeholders highlighted the need for interpreters (especially for Spanish-speaking clients), extended service hours beyond 9am-5pm and including weekends, reserved appointment times to rapidly engage newly diagnosed clients, utilization of engagement standards, expanded use of peer navigators, and the creation of a user-friendly environment.

> *To serve clients well is to know, and use, their preferred language.*
>
> *-PLWH stakeholder*

Poor customer service was also discussed from the perspective of agency staff who felt unable to provide the best care possible because of feeling "overwhelmed" or "burned out" due to a lack (or poor quality) of training, case/client overload, a lack of providers and staff to fulfill needed roles, lack of comprehensive services available in-house, and lack of time with clients to explain/teach about their diagnosis. Stakeholders requested additional staffing, specialized case managers, bilingual staff, changes to staff utilization within agencies, improving infrastructure, and expansion of resources within and across agencies.

Underlying issues. Across the state, stakeholders identified "underlying issues" that negatively impacted testing, linkage to care, and retention in care efforts. Underlying issues included mental health challenges, substance use disorders, housing instability, lack of primary care, intimate partner violence, behavioral health, lack of a social support system, lack of documentation, lack of consistent insurance coverage, financial hardships, and competing priorities (e.g., work, school). To address these barriers, stakeholders suggested more collaborations across agencies to share needed services and resources, additional funding to provide comprehensive services within each agency, and creation and adherence to a rapid linkage to care protocol.

> *We have people who can't pay their rent or are homeless and for them, HIV is not a top priority. If we could help them with housing, we could begin to build trust.*
>
> *-Stakeholder*

GAPS IN SERVICES

Corrections navigation pilot. DHEC has a strong collaborative partnership with county jails and state prisons. Over the past two decades, DHEC provided periodic HIV testing to jailed inmates directly through the Expanded HIV Testing Program and indirectly through the Minority AIDS Initiative. DHEC also funded community partners to provide HIV education and training to incarcerated men and women over several decades. Upon release, some of the trained men and women provided volunteer services as American Red Cross HIV instructors in their communities. DHEC also supported an inmate discharge planning program as part of its Ryan White funding to community providers.

To close the gap of services for incarcerated inmates released to the community, DHEC will partner with the South Carolina Department of Corrections (SCDC) and organizations around the state to ensure current discharge planning programs are expanded and aligned with the statewide EHE Rapid Continuum of Care Program. Enhancements will include:

- Prevention (Rapid Diagnosis, Rapid Linkage, Pre-Exposure Prophylaxis [PrEP], HIV Home and STI test kits, Post-release care packages, Disease Intervention Specialist [DIS]);
- Care and Treatment (Rapid Care Engagement, Medication Adherence and Antiretroviral Therapy [ART] via Health Department, Outreach, Data to Care, DIS or TCM);
- Engagement (Outreach, Data to Care, and Real-time Health Exchange);
- Surveillance (Rapid data entry);
- Ryan White Part B (Discharge planning, AIDS Clinical Training Center (AETC) [Telehealth, TelePrEP], Peer Navigation, Medical Case Management, 18 months post-release monitoring and coaching;
- SCDC (Pre-release medical oversight, Rapid inmate access, and Educational classes); and
- County Jails (Real-time data health exchange).

This vulnerable population along with providers, discharge planners, and community advocates will be invited to participate in an incarceration advisory board group. This group will meet to discuss barriers to care, decimalization laws, new grant initiatives around inmates, policies, and best practices.

Guide to help with PrEP clinic set-up. To increase PrEP access, some agencies are eager to create their own in-house PrEP clinic and delivery system. Unfortunately, their efforts have been hampered because there is no readily available guide that outlines the steps for implementing such a clinic. Identifying or creating such a guide would be helpful to agencies.

> *We're eager to offer PrEP to our clients but don't know where to begin and who to bring to the table.*
>
> *-Stakeholder*

Surveillance Data. Stakeholders noted that in order to provide efficient cluster response, surveillance data would need to be updated in a timelier fashion as it is often "lagging and not current." Further, data is not shared across the state, often stored in non-compatible software systems (e.g., EHARS and SCION are not consistent data systems), and not always comprehensive (e.g., EHARS does not collect ethnicity). Also, the data quality of surveillance data can have problems and therefore May not always providing an accurate picture. Moreover, security and confidentiality laws inhibit the sharing of information across systems and agencies thereby hindering the identification and response to a cluster outbreak. These feedback from stakeholders suggest some misconception of surveillance processes and data systems. In order to provide the most accurate and complete data to the public, surveillance data goes through a complex cleaning and deduplication process (and numbers can, and will, change dramatically during that process). Surveillance data systems are continuously updated, as new lab tests and other information are imported or manually entered daily. Data reports that are used to fulfill data requests may be considered "lagging and not current" because the data Is a year behind due to the data cleaning processes conducted by surveillance. Some suggestions from internal stakeholders suggest ensuring the accuracy of data from providers and laboratories initially could help to ensure data is received in a timelier manner with minimal data clean-up efforts from surveillance. Often, surveillance receives inaccurate demographic information that is updated during the cleaning process. Surveillance data systems have the capacity to collect and receive all demographic information, including ethnicity, but this information is not always provided directly to surveillance from all laboratory or provider reports and must be collected during follow-up procedures. Surveillance and stakeholders will need to work together more closely to create a solution to more initial complete data reporting in order to create timelier data on the front-end which may assist with minimizing data clean-up efforts through surveillance processes.

Collaboration. During discussions of prevention, testing, linkage to care, and cluster response, the need for collaborations was noted repeatedly. Stakeholders believe effective collaborations would allow for connectivity across data systems to identify those in need of reengagement into care as well as those in need of retention into care when changing locations or providers. Effective collaborations would also provide the ability to share resources and specific services across agencies in order to enhance rapid linkage to care and in some cases provide a "one- stop-shopping" experience for clients. Collaborations would also allow for the sharing of resources in covering PrEP-associated lab costs that pose a barrier to PrEP uptake and ongoing adherence. Stakeholders called for the creation, strengthening, or re-activation of collaborations in their respective regions.

SUCCESSES AND NEEDS BY PUBLIC HEALTH REGION

Upstate. Stakeholders in the Upstate Region identified the following successes in terms of prevention, linkage to, and retention in, care:

- CTR program is strong in this region.
- On-going collaborations with community PRIDE and SHAPE programs allows for testing sites and dispersing education and prevention materials.
- Prisma Health has integrated HIV testing in EDs and primary health care settings.
- Data to Care is utilizing facetime and skype to accomplish their linkage efforts.
- The Phoenix Center has started offering HIV rapid testing.
- Telehealth has allowed for continuity of care services.

In addition to the suggestions noted above for all Public Health Regions, specific areas that stakeholders suggested needing expansion in the Upstate include:

- Efforts to reach high-risk negatives
- Efforts in the hospital system and primary clinics to provide routine opt-out testing
- Collaboration efforts with community stakeholders

Midlands. Stakeholders in the Midlands Region identified the following successes in terms of prevention, linkage to, and retention in care:

- Peer advocates in clinics assist clients with linkage to care and ongoing care.
- PrEP navigators at PALSS assist clients with PrEP linkage and adherence.
- Adequate number of HIV providers in this region.
- Youth groups at the Immunology Center are part of the HIV testing process.
- HIV education is part of the curriculum for medical and nursing students.
- Some mobile units are available to reach rural areas.
- Community AIDS Network provides rapid test kits on their mobile outreach units.
- PrEP telehealth in collaboration with UofSC.
- UofSC AETC new initiative to provide PrEP in health departments and at DAODAS via telehealth – helps community health centers and ERs to identify individuals who qualify for PrEP.

In addition to the suggestions noted above for all Public Health Regions, specific areas that stakeholders suggest in the Midlands include:

- Increase opt-out testing in primary care offices
- Increase education, encouragement, and support to those newly diagnosed to help them through the DIS process and notifying partners
- Increase more primary care providers taking on long-term HIV care management
- Increase number of peer navigators
- Increase outreach into rural areas
- Re-engage collaborations among providers and agencies to share resources and enhance service delivery to clients

Lowcountry. Stakeholders in the Lowcountry Region identified the following successes in terms of prevention, linkage to, and retention in care:

- SHAPE partnerships to host events
- Increased testing by incentivizing testing events, using social media campaigns, and coupling meal distribution with testing
- Alternative service hours (beyond 9am-5pm and on weekends)
- Partnering with other agencies to share resources
- Providing HIV testing with other health screening at community events
- Co-case management
- Rapid linkage to care
- Some one-stop-shopping clinics
- Telemedicine/telehealth
- Sharing education/messaging via Spanish language radio in Hilton Head
- MUSC Family Medicine provides TelePrEP services, which addresses some of the barriers to PrEP uptake, such as accessibility and privacy. (Through a partnership with DHEC, these services will become available to health department clinics in the Lowcountry Region.)

In addition to the suggestions noted above for all Public Health Regions, specific areas that stakeholders suggested needing expansion in the Lowcountry include:

- Same day clinics to enhance rapid linkage/re-engagement to care
- In-house mental health providers
- Outreach into rural areas
- Statewide case management systems
- Collaborations with other agencies to provide more comprehensive services and rapid linkage to care

Pee Dee. Stakeholders in the Pee Dee Region identified the following successes in terms of prevention, linkage to, and retention in care:

- Increased opt-out testing
- Utilization of telehealth for HIV and PrEP education
- Partnerships between providers and schools and the regional health department and DIS
- Social media to advertise services (prevention and care)
- Partnering with other testing events
- Providing linkage to transportation
- Increased telehealth visits
- Condom distribution in non-traditional settings (motels)
- Collaborations with MSM groups
- Increased HIV rapid testing in AOD facilities

In addition to the suggestions noted above for all Public Health Regions, specific areas that stakeholders suggested needing expansion in the Pee Dee include:

- Increased mobile clinics and telehealth for rural areas
- Provision of internet hot spots in rural areas to allow for telehealth and health-related apps

SPECIAL POPULATIONS

PWID. During the discussions of HIV prevention, testing, and care needs among people who inject drugs (PWID), stakeholders insisted that a fundamental key in engaging PWID about HIV-related services was to first identify and address general PWID barriers. The following were noted by stakeholders as general barriers to PWID in South Carolina:

- Lack of syringe service programs (lack of federal funding for syringes and paraphernalia laws not allowing for the distribution of sterile syringes)
- Lack of accessibility to sterile equipment
- Lack of transportation to access services
- Lack of general substance use disorder knowledge and awareness among the public, medical providers, and those who can bring about changes to the current paraphernalia laws – contributing to stigma and discrimination
- Law enforcement presence
- Lack of documentation needed to access services (driver's license, birth certificate, ID cards, etc.)
- Too few disposal sites

When we reduce stigma against PWID, we will help the Syringe Service Program legislation pass.

-Stakeholder

Stakeholders shared that addressing some of these barriers is not possible at this time given legislative restrictions. However, they did offer the following activities to address some of the barriers noted above for PWID and also for engaging PWID in HIV prevention, testing, and care:

- Increase public education about SUD, HIV, and PrEP
- Increase training for clinical providers (including first responders and pharmacists)
- Provide access to sterile items allowable by law (e.g., fentanyl testing strips, alcohol pads, etc.)
- Collaborate with hospitals and treatment centers to provide education and options for recovery to coincide with HIV services
- Increase peer navigators who have shared experiences to assist clients
- Collaborate with AETC to share educational resources
- Increase medical monitoring services for PWID

PWID experience outright discrimination and vile treatment if they go to the ER with a medical issue. We need to get enlightened doctors to speak with their peers. Doctors listen only to other doctors.

-Stakeholder

Latinx. Stakeholders attending the Latinx forums noted many similar HIV prevention, testing, and care needs among Latinx communities as other communities engaged in earlier discussions. Similar needs include:

- expanded access to free HIV testing
- more clinics offering PrEP (including those inclusive of the LGBTQA+ community)
- enhanced culturally appropriate marketing and education tailored to specific

groups (e.g., youth, older adults, women, etc.)
- expanded anti-stigma campaigns
- culturally sensitive/competent and care-centered clinics with bilingual staff
- expanded availability of services and routine testing in alternative non-HIV settings (e.g., primary care clinics, pharmacies, ERs, etc.) that allow for enhanced confidentiality
- expanded social media apps to market services and connect with services
- rapid linkage to care, case management, and mental health services to newly diagnosed clients
- expanded mobile outreach and telehealth services

When working with the Latinx community, it is important to note:
- Latin women are more receptive to participating in prevention programs and testing compared to their male counterparts.
- The Latinx community requires discretion, confidentiality, and well trained, culturally competent professionals with whom to discuss sexual risk behaviors without being required to label gender identity or gender orientation (especially among men).
- Distribution of condoms and other HIV prevention services must be offered more discreetly so they will be willing to access the service.
- Relationships with the Latinx community must be fostered on an on-going basis, not just when agencies need testing numbers.
- Television, radio, and newspapers are common ways to access this population with education messages.
- If identification is required for services, work with agencies to provide an alternative identification card (e.g., North Carolina has such a program) so as to avoid hurdles for those without documentation.
- All materials (fact sheets, brochures, webpages) should be in Spanish (with multiple dialects represented).
- Racism is alive and well and has been experienced by most in the Latinx community which can create a barrier to services.

Continue creating Latinx forums to talk about issues that need improvement and [to help] the Latinx community feel more welcome and included in South Carolina…
-Stakeholder

Specific needs for the Latinx community include:
- All materials (fact sheets, brochures, webpages) should be in Spanish (including versions across tailored to different prominent dialects).
- Bilingual staff is a must for providing prevention and care services including DIS.
- Refer newly diagnosed clients to locations that provide Ryan White funded programs.
- Increase follow up services with the agricultural migrant worker so they do not fall out of care.
- Advocacy training to re-engage with, and serve on the HIV Planning Council.

EHE PLAN BY STRATEGY: DIAGNOSE, TREAT, PREVENT & RESPOND

At the heart of the South Carolina EHE implementation plan are four fundamental strategies or pillars as noted in the national plan:

- **DIAGNOSE** all individuals with HIV as early as possible after infection;
- **TREAT** HIV infection rapidly after diagnosis and effectively in all people who have HIV, to help them get and stay virally suppressed;
- **PREVENT** HIV infections using proven prevention interventions, including PrEP and syringe services programs; and
- **RESPOND** rapidly to potential HIV outbreaks to get prevention and treatment services to people who need them.

DIAGNOSE

Outcome Objective –

By December 31, 2024, at least 90% of South Carolinians living with HIV will be aware of their HIV status.

Program Objectives –

By December 31, 2022:

- Up to 12 DHEC-funded agencies and/or health departments will institute HIV home testing programs in their operations.
- DHEC will conduct an analysis and promote enhanced HIV testing opportunities in at least 10 RW organizations targeting partners of clients currently in care.
- Up to 12 health departments will demonstrate a 20% increase in HIV testing in STI clinics.
- DHEC will contract with up to 4 HIV prevention CBOs with existing mobile units to provide HIV testing in rural gap service areas and on college campuses.
- DHEC will partner with the “FOCUS Initiative” to work with emergency departments to modify the electronic medical record to alert providers to order an HCV and HIV test for each client receiving services..
- DHEC will expand routine HIV testing with at least four partner agencies.

By December 31, 2024:

- DHEC will contract with up to 5 HIV prevention CBOs with existing mobile units to provide HIV testing in rural gap service areas and on college campuses.

TREAT

Outcome Objectives –

By December 31, 2024:

- More than 90% of newly diagnosed individuals will be linked to care within 14 days of receipt of their HIV test results.
- More than 75% of newly diagnosed individuals will be initiated on ART within 30 days of receipt of their HIV test results.

Program Objectives –

By December 31, 2021:

- DHEC will review and revise as needed rapid linkage to care protocols to establish expectations/send monitoring and evaluation standards.
- DHEC will review and revise as indicated protocols for rapid initiation of ART establishing statewide expectations/monitoring and evaluation standards.
- DHEC will review subrecipient staffing needs for providing rapid re/engagement.
- DHEC will hire ADAP staff to support the rapid eligibility and enrollment of newly diagnosed and returning to care clients referred to ADAP through Rapid Linkage and Treatment programs.
- DHEC will maintain at least one DHEC-based social worker in each public health region to provide rapid linkage to HIV treatment and care services for persons newly diagnosed with HIV.
- DHEC to develop and deliver a trauma-informed care training reaching at least 50 providers from at least 10 community agencies or health departments.

By December 31, 2022:

- DHEC will award with RWB EHE funds 4 entities for Rapid Engagement and Rapid ART expansion and initiation, which includes funding for needed new medical case management and clinical positions for client linkage and clinical services.
- At least 6 new organizations will receive training in ARTAS and be delivering the intervention with newly diagnosed individuals.
- DHEC will engage at least 4 community partners in the development of correctional navigation pilot using Project START + as the intervention approach.
- DHEC will support staffing in at least 6 RW sites to meet behavioral health needs, including mental health and substance abuse skills.
- DHEC will develop a training series for prevention/care managers on staff retention and supportive supervision and staff from at least 15 funded agencies will participate.
- DHEC will analyze existing protocols and revise protocols for rapid re-engagement in care services which will establish a statewide standard and allow for monitoring guidelines.
- DHEC will increase the number of PLWH who receive housing assistance through the HOPWA program by 5%.

- DHEC will support at least two community partners in the development of effective, replicable pilot projects to decrease barriers to transportation for PLWH.

By December 31, 2024:

- At least 6 new organizations will initiate or expand peer navigation and peer adherence services utilizing PLWH.

PREVENT

Outcome Objective –

By December 31, 2024, there will be a 75% reduction in new HIV cases in South Carolina.

Program Objectives –

By December 31, 2021:

- DHEC will develop or futehr promote an implementation guide to assist providers with establishing and integrating PrEP services into clinic flow and disseminate via the DHEC PrEP web page.
- DHEC will maintain at least one DHEC-based social worker in each public health region to provide PrEP assessments and rapid linkage to navigation services provided by community-based partner agencies.
- DHEC will provide support for covering PrEP laboratory costs for up to 100 clients annually.

By December 31, 2022:

- DHEC will support the expansion of PrEP navigation services with up to 8 HIV prevention CBOs.
- DHEC will develop an online training on PrEP for up to 40 clinicians who will take advantage of this opportunity.
- Up to 4 HIV prevention CBOs will expand services for Latinx clients by adding bilingual/bicultural staff.
- DHEC will provide support for up to 6 organizations to provide HIV testing and screening for PrEP for persons who inject drugs (PWID), along with prevention supplies and referrals to treatment (using a harm reduction model).
- DHEC will assist community partners by sharing current data on the needs of PWID and the benefits of harm reduction programs.

RESPOND

Outcome Objective –

By December 31, 2024, DHEC and community partners will have all systems in place for seamless response to HIV outbreaks in South Carolina.

Program Objectives –
By December 31, 2021:

- DHEC will analyze the makeup of and potentially expand the existing Cluster Response workgroup.
- DHEC will Increase communication/education between Surveillance and partners to minimize misconception (or to bring awareness) of surveillance systems and processes.

By December 31, 2022:

- DHEC will analyze/expand current protocols to enhance data sharing between DHEC and external partners and among external partners who receive DHEC funding.
- A Cluster Response working group will meet at least quarterly to prepare and plan for response and to debrief and incorporate learning following outbreaks.
- DHEC will support the establishment of a rapid multi-disciplinary response team of internal and external partners who will lead the frontlines in addressing outbreaks and clusters.

STIGMA REDUCTION

In order to foster an enabling environment, DHEC will engage in a number of statewide efforts aimed at building awareness and addressing stigma surrounding HIV.

Outcome Objective – By December 31, 2024, up to 10 DHEC-funded agencies will add additional prevention/care services to move toward a model of service bundling.

Program Objectives –
By December 31, 2021:

- DHEC will develop a customer service/client-centered culture training with participation from up to 15 funded organizations.
- DHEC will develop and deliver at least two anti-stigma trainings reaching at least 50 providers from at least 10 community agencies or health departments.
- DHEC will provide technical assistance for up to 8 funded organizations to enhance the use of or access to telehealth services.

By December 31, 2022:

- DHEC will revise the DHEC website to offer enhanced community education/ messaging.
- DHEC will support up to 8 agencies with funding for CDC-developed, anti-stigma campaigns on social media platforms.
- DHEC will re-vamp and/or create directories about PrEP, prevention, and RW services and make them easily accessible on DHEC's website.
- DHEC will collaborate with up to 4 existing mobile service providers to

incorporate HIV testing or clinical care services into existing health services.

- Up to 4 DHEC-funded agencies will hire bilingual/ bicultural staff to enhance services to Latinx clients.
- DHEC will develop a comprehensive capacity-building initiative to provide mentoring to new and emerging community groups an opportunity to advance as nonprofit organizations.
- DHEC will work with NASTAD on building the capacity of PLWH to provide input at health departments and community forums.